

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

1 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

11755

CERTIFICATE OF DEATH

11755

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		STATE <u>MD</u>		COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Preston</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston, MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Ulyses G. Adams</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 12 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>8/14/77</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmes</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Adams</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Camper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mrs Mary Adams Preston MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) <u>Chronic Congestive Heart Failure</u>						4 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis Generalized</u>						10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Chronic Glomerular Nephritis</u>						4 yrs	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 10</u> , 19 <u>40</u> , to <u>12/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>55</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James B. Plummer</u>		ADDRESS (Street, city, town, state) <u>Preston, Maryland</u>		DATE SIGNED <u>12/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant cem.</u>		LOCATION (City, town, or county) (State) <u>Preston, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Cornelia W. Plummer</u>		25a. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Plummer</u>		ADDRESS <u>Easton, Md.</u>	
DATE <u>12-16-55</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11756

CERTIFICATE OF DEATH

11756

Reg. Dist. No. 64

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Federalsburg</u>		<u>31 years</u>		TOWN <u>Federalsburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>109 West Central Avenue</u>				STREET ADDRESS (If rural give location) <u>109 West Central Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Margaret</u>		(Middle) <u>Stayton</u>		(Last) <u>Anderson</u>		(Month) (Day) (Year) <u>December 14 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>January 4, 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Home</u>		<u>Greenwood, Delaware</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Nehemiah Stayton</u>				<u>Mary Jane Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Jacob O. Williams, Federalsburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>199.1</u> IMMEDIATE CAUSE (A) <u>Broncho-pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cachexia</u>						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Squamous cell carcinoma, lt. ear</u>						<u>5 mon.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive cardiovascular disease.</u>						<u>7 mon.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>May 1955</u>		<u>Squamous cell carcinoma, lt. ear</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-2-</u>, <u>1955</u>, to <u>12-13</u>, <u>1955</u>, that I last saw the deceased alive on <u>12-13</u>, <u>1955</u>, and that death occurred at <u>12:15A</u>, from the causes and on the date stated above.							
SIGNATURE <u>R. C. Kingsbury</u>				ADDRESS (Street, city, town, state) <u>Federalsburg, Maryland</u>			
				DATE SIGNED <u>Dec. 15, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 16, 1955</u>		<u>Hill Crest Cemetery</u>		<u>Federalsburg, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE</u> <u>Dec. 16, 1955</u>		<u>Margaret H. Frampton</u>		<u>J. J. Frampton and Son, Federalsburg, Md.</u>			

1108 CERTIFICATE OF DEATH

Form 10-1-54

1. NAME OF DECEASED (Print or Write)

2. SEX () Male () Female

3. AGE () Years () Months () Days

4. DATE OF BIRTH () Year () Month () Day

5. PLACE OF BIRTH () State () County () City ()

6. OCCUPATION ()

7. MARITAL STATUS () Single () Married () Widowed () Divorced

8. EDUCATION () Years () Months () Days

9. RELIGION ()

10. RACE () White () Black () Other ()

11. CAUSE OF DEATH ()

12. MANNER OF DEATH ()

13. PLACE OF DEATH ()

14. TIME OF DEATH ()

15. SIGNATURE OF DECEASED ()

16. SIGNATURE OF WITNESS ()

17. SIGNATURE OF PHYSICIAN ()

18. SIGNATURE OF CORONER ()

19. SIGNATURE OF JURY ()

20. SIGNATURE OF JUDGE ()

21. NAME OF DECEASED (Print or Write)

22. SEX () Male () Female

23. AGE () Years () Months () Days

24. DATE OF BIRTH () Year () Month () Day

25. PLACE OF BIRTH () State () County () City ()

26. OCCUPATION ()

27. MARITAL STATUS () Single () Married () Widowed () Divorced

28. EDUCATION () Years () Months () Days

29. RELIGION ()

30. RACE () White () Black () Other ()

31. CAUSE OF DEATH ()

32. MANNER OF DEATH ()

33. PLACE OF DEATH ()

34. TIME OF DEATH ()

35. SIGNATURE OF DECEASED ()

36. SIGNATURE OF WITNESS ()

37. SIGNATURE OF PHYSICIAN ()

38. SIGNATURE OF CORONER ()

39. SIGNATURE OF JURY ()

40. SIGNATURE OF JUDGE ()

BUREAU V. S.

DEC 28 1955

RECEIVED

INSTRUCTIONS

1. This form is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. 2. The cause of death should be stated in as few words as possible, but in such a way as to give a clear and concise statement of the facts. 3. The manner of death should be stated in as few words as possible, but in such a way as to give a clear and concise statement of the facts. 4. The place of death should be stated in as few words as possible, but in such a way as to give a clear and concise statement of the facts. 5. The time of death should be stated in as few words as possible, but in such a way as to give a clear and concise statement of the facts. 6. The signature of the deceased, if known, should be written in the space provided. 7. The signature of the witness, if known, should be written in the space provided. 8. The signature of the physician or coroner, if known, should be written in the space provided. 9. The signature of the jury, if known, should be written in the space provided. 10. The signature of the judge, if known, should be written in the space provided. 11. This form is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. 12. The cause of death should be stated in as few words as possible, but in such a way as to give a clear and concise statement of the facts. 13. The manner of death should be stated in as few words as possible, but in such a way as to give a clear and concise statement of the facts. 14. The place of death should be stated in as few words as possible, but in such a way as to give a clear and concise statement of the facts. 15. The time of death should be stated in as few words as possible, but in such a way as to give a clear and concise statement of the facts. 16. The signature of the deceased, if known, should be written in the space provided. 17. The signature of the witness, if known, should be written in the space provided. 18. The signature of the physician or coroner, if known, should be written in the space provided. 19. The signature of the jury, if known, should be written in the space provided. 20. The signature of the judge, if known, should be written in the space provided.

11757

11757

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 64

1. PLACE OF DEATH:

COUNTY Caroline MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Federalsburg LENGTH OF STAY (in this place) 10 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS River Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Caroline

CITY (If outside corporate limits write RURAL and give nearest town) Federalsburg

STREET ADDRESS (If rural, give location) River Road

3. NAME OF DECEASED:

(First) Charles (Middle) Wesley (Last) Dickerson

(Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)
December 7 1955

5. SEX:

Male

6. COLOR OR RACE:

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH:

Feb. 21, 1878

9. AGE last birthday: 77 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Federalsburg, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Charles Henry Dickerson

14. MOTHER'S MAIDEN NAME:

Ann Maria Thomason

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 183-20-8497

17. INFORMANT & ADDRESS:

Louise Bolden, Wilmington, Delaware

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1
Immediate cause

(a) Cardiovascular Disease
DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

Several yrs.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Landon D. George

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☒

12/8/55
(State)

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

Dec. 12, 1955

NAME OF CEMETERY OR CREMATORY

Federal Hill Cemetery

LOCATION (City, town, or county)

Federalsburg, Maryland

DATE REC'D BY LOCAL REG.

December 8, 1955

REGISTRAR'S SIGNATURE

Margaret N. Frampton

24. FUNERAL DIRECTOR

J.J. Frampton and Son, Federalsburg, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11758

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12577 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
X TOWN <u>Federalsburg - Rural</u>		<u>3 months</u>		TOWN <u>Federalsburg - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Allen's Corner</u>				STREET ADDRESS (If rural, give location) <u>Near Allen's Corner</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Clarence</u>		(Middle) <u>Duley</u>		(Last)	
4. DATE OF DEATH		(Month) <u>December</u>		(Day) <u>25</u>		(Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>C colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>December 30, 1913</u>	9. AGE last birthday: <u>41</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Logging</u>		11. BIRTHPLACE (State or foreign country): <u>Rocky Mount, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Mary B. Duley, Federalsburg, Maryland</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a)..... <u>Hemorrhage - Shock</u> DUE TO Antecedent cause(s) (b)..... <u>Gun Shot Wound, 17 Chest</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							<u>few minutes</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) <u>Federalsburg</u> (County) <u>Caroline</u> (State) <u>2nd</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-25-55 9:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Gun Shot Wound -</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lincoln S. George</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>12/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan. 3, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 3, 1956</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

BUREAU V. S.

JAN 9 1950

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

11759

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

12578

Reg. Dist. No. 63

1. PLACE OF DEATH: COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston RY</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston RY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		First (Last)		Middle (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Effie</u>		<u>Sayer</u>		<u>Engle</u>		<u>Dec.</u> <u>12</u> <u>1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year If under 24 hrs.		
<u>F</u>	<u>W</u>	<u>WIDOWED</u>	<u>12/5/1881</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>N.W.</u>				<u>—</u>		<u>Kansas</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Calvin Seerist</u>				<u>Hannah Wese</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT	
<u>—</u>				<u>no</u>		<u>Rene Engle - Preston Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>420.1</u> (a) <u>Myocardial Infarction</u>						<u>3 weeks</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arteriosclerotic Coronary Disease</u>						<u>1 yr</u>	
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/1/1</u> , 19 <u>54</u> , to <u>12/12/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/10/1</u> , 19 <u>55</u> , and that death occurred at <u>—</u> m., from the causes and on the date stated above.							
SIGNATURE <u>M. E. Engle</u>				ADDRESS <u>Md.</u>		DATE SIGNED <u>Easton Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/14/55</u>		<u>Leicester</u>		<u>Preston Md RY</u>	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/13/55</u>		<u>A. H. Neeris</u>		<u>M. E. Neuman + Son - Easton Md</u>			
<u>Cornelia D. Plummer</u>							

TWO FOR ONE CERTIFICATE Film #191 - 1/20/56
Mnt.

BUREAU V. S.

JAN 17 1956

RECEIVED

11760

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Greensboro</u>		33 Yrs.		OR TOWN <u>Rural Greensboro</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
None				None			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)		OF DEATH: 12 19 55 19	
L.		Anna		Harper			
(Type or Print)							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED,		8. DATE OF BIRTH:	
Female		White		Widowed		3/4/1899	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
66 yrs.		Months Days		Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife				None		Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
U.S.A.				Thomas Hignutt			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
Rachel Nicholes				None			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS:			
				Wm. C. Harper Greensboro, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE							
(A) Coronary Thrombosis							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) Atherosclerotic Cardiovascular Disease							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 10., 1955 to Dec. 19., 1955 that I last saw the deceased alive on Dec. 19., 1955, and that death occurred at 8A. M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Charles H. Stouffer		Greensboro, Caroline		12/22/55			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12/22/55		Greensboro		Greensboro, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		14. FUNERAL DIRECTOR		ADDRESS	
12/22/55		L. MacP... ..		J. E. Boula... ..		Greensboro, Md.	

MARGIN RESERVED FOR BINDING

11761 CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>		LENGTH OF STAY (in this place) <u>25 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Greensboro</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>William</u>		(Middle) <u>Henson</u>		(Last) <u>Melvin</u>			
(Type or Print)				OF DEATH: <u>12</u> <u>16</u> <u>55</u>		<u>19</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>		<u>7/14/1880</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Carpenter</u>		<u>None</u>		<u>Delaware</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James A. Melvin</u>				<u>Mary Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>214-12-5641</u>		<u>Bertha Melvin Greensboro, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE							
(A) DUE TO <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE (S)							
(B) DUE TO <u>Arteriosclerosis Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Diabetes Mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 16, 1955</u> , to <u>Dec. 16, 1955</u> , that I last saw the deceased alive on <u>Dec. 16, 1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Charles H. Stauffer</u>		<u>Greensboro, Caroline Co. Md.</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/19/55</u>		<u>Silverbrook</u>		<u>Wilmington, Del.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/19/55</u>		<u>L. M. Pappin</u>		<u>J. E. Bouhais</u>		<u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

814-15-2641

BUREAU V. S.

DEC 21 1955

RECEIVED

of Bureau of Internal Revenue, W. H.

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11762

CERTIFICATE OF DEATH

11760

Reg. Dist. No. 62

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Denton</u>		<u>life</u>		TOWN <u>Denton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>SAMUEL GRAHAM NUTTLE</u>				<u>DEC. 7, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>Widowed</u>	<u>July 18, 1868</u>	<u>87</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Young</u>		<u>Farm owner</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Tilghman Nettle</u>				<u>Emmaline Taylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Eura Martin Voss, Denton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
196X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Cancer of Lower Mandible.</u>						<u>6 mos</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>June 14, 1954</u>, to <u>Dec. 7, 1955</u>, that I last saw the deceased alive on <u>Dec 7, 1955</u>, and that death occurred at <u>3:20 P.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Amos D. George</u>				<u>Denton Md. 12/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>Denton</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12/8/55</u>		<u>Amos D. George</u>		<u>G. Virgil Hoover for</u>		<u>Denton, Md.</u>	

BUREAU V. S.

DEC 12 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Goldsboro</u>		LENGTH OF STAY (in this place) <u>47 Yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Goldsboro</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Agnes Virginia Seward</u>				<u>12 22 55 19</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>4/16/1908</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Norman Seward</u>				14. MOTHER'S MAIDEN NAME: <u>Maggie Sculley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Norman Seward Goldsboro, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Exhaustion</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Cerebral Anemorrhage</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Intestinal Nephritis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/22/55</u> to <u>12/22/55</u> , that I last saw the deceased alive on <u>12/22/55</u> , 19 <u>55</u> , and that death occurred at <u>55A</u> M. from the causes and on the date stated above.							
SIGNATURE <u>J. E. Boulaie</u>		M. D. <u>Goldsboro</u>		DATE SIGNED <u>12/23-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/24/55</u>		REGISTRAR'S SIGNATURE <u>J. E. Boulaie</u>		24. FUNERAL DIRECTOR <u>J. E. Boulaie</u>		ADDRESS <u>Greensboro, Md.</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 9 1956

RECEIVED

11/29/77

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11762

11764

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Preston - Rural</u>		LENGTH OF STAY (in this place) <u>10 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston - Rural</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>Smithson</u>				STREET ADDRESS (If rural give location) <u>Smithson</u>		<u>/</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>George</u> (Middle) <u>Truitt</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>December</u> <u>6</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>October 11, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Sussex County, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Truitt</u>				14. MOTHER'S MAIDEN NAME <u>Julia Burton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Charles L. Perry, Preston, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerotic Heart Disease</u>						<u>6 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/20</u> , 19 <u>51</u> , to <u>12/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/6</u> , 19 <u>55</u> , and that death occurred at <u>11:30AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harry B. Plummer</u> M.D.				ADDRESS (Street, city, town, state) <u>Preston, Maryland</u>		DATE SIGNED <u>Dec. 7, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 9, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bridgeville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bridgeville, Delaware</u>	
24. REC'D BY REGISTRAR <u>12-7-55</u>		REGISTRAR'S SIGNATURE <u>Cornelia D. Plummer</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.J. Frampton and Son, Federalsburg, Md.</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11765

Item 21f Film 6191 1-9-55 ans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11763

Reg. Dist.

No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Federalsburg</u>		<u>Life</u>		TOWN <u>Federalsburg</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Denton Road</u>				STREET ADDRESS (If rural, give location) <u>Denton Road</u>			
3. NAME OF DECEASED: (First) <u>James</u>		(Middle) <u>Carlton</u>		(Last) <u>Walls</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 20 1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>		8. DATE OF BIRTH: <u>Dec. 6, 1898</u>	
9. AGE last birthday: <u>57</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>House Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Painting</u>		11. BIRTHPLACE (State or foreign country): <u>Caroline County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>J. Gardner Walls</u>				14. MOTHER'S MAIDEN NAME: <u>Sallie Polite</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>William P. Walls, Salisbury, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
916.0 Immediate cause (a) <u>Asphyxiation</u>						<u>Immediate</u>	
Antecedent cause(s) DUE TO (b) <u>3rd Degree Burn entire Body</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO (c)							
stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) <u>05</u> (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12 20 55 12 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? (not a collision) <u>Burned in auto mobile</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Dwight Dr. George</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/20/55</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec. 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 20, 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

BUREAU V. S.

DEC 28 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u>		LENGTH OF STAY (in this place) <u>40 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>H</u> (Middle) <u>Zacker</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/9/1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign, country) <u>Philadelphia, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Zacker</u>				14. MOTHER'S MAIDEN NAME <u>Selma Kleinwachter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>William Kleinwachter</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Home</u> <u>1955</u> <u>after death</u> , that I last saw the deceased alive on <u>12/10/55</u> , and that death occurred at <u>4:45</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Lester O. George</u>		DATE THEREOF <u>12/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Jr. O.U.A.M.</u>		LOCATION (City, town, or county) <u>Preston Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Cornelia W. Plummer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.M. Hall</u>		ADDRESS <u>Ston, Md.</u>	
DATE <u>12-14-55</u>							

